DOCUMENT RESUME

ED 174 818 CE 022 422

TITLE	Education of Managers in Health Services. Report on a Working Group. Dusseldorf: 29 November-2 December 1977.
INSTITUTION	World Health Organization, Copenhagen (Denmark). Regional Office for Europe.
REPORT NO	ICP/HSD-043
PUB DATE	78
NOTE	45p.
EDRS PRICE	MF01/PC02 Plus Postage.
DESCRIPTORS	*Health Personnel; *Health Services; *Management Education; Nurses; Physicians; Program Development; Public Policy; Research Needs
IDENTIFIERS	*Europe; World Health Organization

ABSTRACT

Presented is the report by the Working Group on the education of managers in health services in the World Health Organization, European Region. The report is organized into the following sections: health care management and managers; key issues in health service management (public policy-making and health care management, the managerial role of physicians, and the need for improved nursing management); management education in the European region; development of management education programs for health services; health management education and health services research; promotion of national management education programs and role of international collaboration; and recommendations at the national and international levels. Included in the appendices is a working paper titled "Health Management Education and Training," by J.E. Blanpain. (JH)

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ED174818

Education of Managers in Health Services

Report on a Working Group

Düsseldorf
29 November – 2 December 1977

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COPENHAGEN
1978

ICP/HSD 043

CE 022 422

Note

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This report is also issued in French, German and Russian.

CONTENTS

		Page
1.	Introduction	1
2.	Health care management and managers	2
3.	Key issues in health services management	5
	3.1 Public policy-making and health care management	5
	3.2 The managerial role of physicians	9
	3.3 The need for improved nursing management	10
4.	Management education in the European region	12
5.	Development of management education programmes for health services	14
6.	Health management education and health services research	16
7.	Promotion of national management education programmes and role of international collaboration	19
8.	Recommendations	20
	8.1 At the national level	20
	8.2 At the international level	21
References		22
Bibliography		23
Annex I	Health management education and training by Professor J.E. Blanpain	24
Annex II	Agenda	38
Annex III	List of participants	39

1. INTRODUCTION

The Working Group was held at the Academy for Public Health in Düsseldorf from 29 November to 2 December 1977 to discuss the education of managers in health services in the WHO European Region. There were 19 participants, including 14 temporary advisers from 12 countries, 1 consultant and 4 staff members of WHO, at the meeting, convened by the Regional Office for Europe in collaboration with the Government of the Federal Republic of Germany. (For a complete list of participants see Annex III.)

Both WHO headquarters and the Regional Office have considered health management education at previous meetings. The Consultation on the International Programme for Training in Health Management held at WHO headquarters, Geneva, 25–29 October 1977, just prior to the meeting of the Working Group, provided an explicit frame of reference which the Working Group could relate to.

The report of that meeting (*1*) proposed a WHO strategy to improve the management of health sector activities by assisting with national efforts for health management education, as part of the concept of technical cooperative development and in close interaction with other WHO programmes, in particular with country health programming and the integrated development of health manpower. The meeting arose out of a growing awareness that a greater effort in health management education is needed in the countries of the Region because of the increasing complexity and rising costs of health services. Though managerial tasks are different in different services (medical, nursing, administrative) and at different levels of administrative responsibility, all health service managers are nevertheless required to fit their priorities to the overall goals and objectives of their services, to exercise quality control, to promote efficiency and to match their services to the needs of the consumers.

Whereas education programmes for health professionals are available at all levels, education in management for such personnel is largely neglected and tends to be inadequate. As a consequence, implementation of policy decisions throughout the health services may suffer.

While keeping the European situation in mind, the Working Group was specifically asked to:

(1) identify the key elements of the managerial functions in accordance with the overall goals and objectives of health services;

(2) advise on the development of education programmes for health service managers;

(3) discuss provisions for meeting the need for such education programmes and the role of international cooperation in this field.

The meeting was opened, on behalf of Ms Antje Huber, Federal Minister for Youth, Family Affairs and Health of the Federal Republic of Germany, by Professor L. von Manger-Koenig, Special Consultant on International Health Affairs to the Minister. In his opening remarks, Professor von Manger-Koenig stressed the importance of health care management not only in its international aspects but even more so in national health policy at a time when all governments are facing the immense problem of how to contain costs without obstructing the efficient delivery of health care.

Dr R. Wiedersheim, Chief, Health Manpower Development at the WHO Regional Office for Europe, conveyed to the Group the greetings of the Regional Director, Dr Leo A. Kaprio, and his hopes that the Working Group would help make national endeavours in health management education more effective. He also hoped strongly that participants would return to their home countries to implement the conclusions of the meeting.

To guide the discussions of the Working Group a working paper on "Health management education and training" (Annex I), prepared by Professor J.E. Blanpain, had been distributed to the participants together with relevant WHO reports (see bibliography).

Dr A. Eberwein was nominated Chairman, Dr J. Vysohlid was elected Vice-Chairman, Professor J.E. Blanpain acted as Rapporteur and Dr J.E. Asvall, Regional Office for Europe, acted as Secretary.

2. HEALTH CARE MANAGEMENT AND MANAGERS

The fact that health costs are rising and health budgets are taking a growing slice out of overall budgets calls for greater managerial efficiency in health matters than ever before, members of the Working Group considered.

Health care management and the role and place of health care managers can be defined in different ways. Many members of the health professions hold a rather negative view of management which they perceive as bureaucratism, control for control's sake or even a sheer nuisance when it interferes in fundamental resource allocation. This poor esteem tends to reflect on the status and position of health care managers. It would be unwise to ignore this situation, which partly results from the fact that health professionals, in particular physicians, often view management as interfering with their clinical freedom of decision in diagnosis and treatment. Conversely, account should be taken of the definite tendency to extend this clinical autonomy beyond decision-making for individual patients, and thereby to attempt to make all health care related decision-making immune from outside interference.

Therefore, the participants considered it necessary to spend some energy and attention to point out the legitimate role and place of health care management, while not discussing in detail general questions of management beyond saying that management basically seeks to satisfy and balance the interests of all the participants in an organization: the clients, the workers in the organization and the broader environment to which the organization relates, and that management aims at optimizing quantitatively and qualitatively the outputs of the organization by these products or services.

Members of the Working Group stated that in the health field, as in other sectors of modern society, the variety of problems encountered presuppose a variety of techniques at widely ranging levels of sophistication in solving them – from operational control in a stable environment, through adaptation in a changing one, and finally deliberately changing the environment itself. As the health manager moves through successive stages of understanding his task as a problem-solving activity, so his approach will pass from analysis through interaction to activities involving search and learning. Like managers in every other field of activity, the health manager must monitor performance in the tasks he is responsible for in terms of their effectiveness (in relation to their goals) and their efficiency (in relation to the use made of resources). In addition to such evaluation he is also responsible for planning, organizing, directing, motivating and coordinating. To do so successfully he must be able to analyse performance data, synthesize and reach decisions on the appropriate responses, and communicate his results.

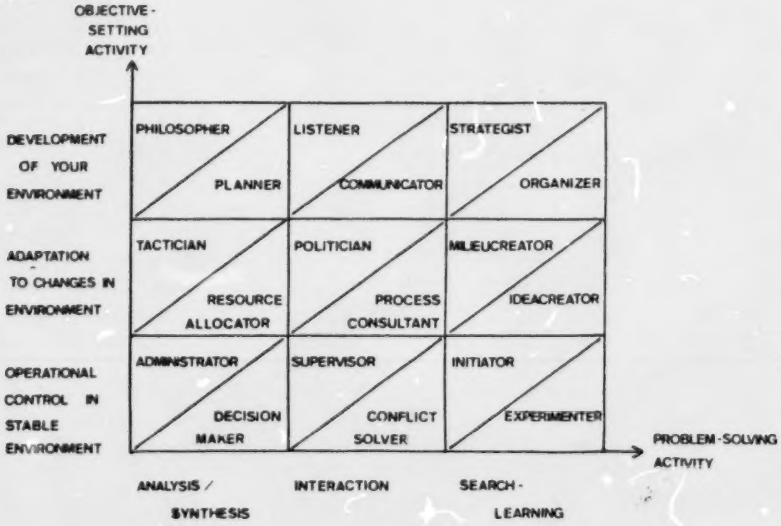
The differences that may arise in emphasis as a result of differing managerial tasks and needs mean that there is room in the health field for various types of manager to bring their own particular personalities to bear on the problems they have to face (see Fig. 1).

Health care management, the Working Group felt, could roughly be defined as a purposeful and efficient use of resources.

Basically a health care manager can be defined as a person responsible for the deployment of resources other than his own time and energy. The Working Group accepted this definition, while stressing that this includes a wider selection of staff than the "traditional" managerial category of hospital directors, etc. Ward nurses, hospital consultants, and so forth would thus be included among persons having managerial functions. Indeed, patient care today has progressed far beyond the conventional mode in which a single health worker interacted with a single patient and by his actions affected negligible resources. Nowadays patient care is routinely provided through health care teams commanding substantial financial and material resources.

Today, for example, a head nurse in a nursing ward "manages" patient care. She assigns patients to different members of her staff by matching her assessment of patient needs to the qualifications she considers that her staff possess. Nursing plans, nursing records and team discussions are some

Fig. 1. Typology of managers



of the management tools used to optimize the nursing care. One could draw similar examples for surgeons in an operating suite or for primary care physicians in a neighbourhood health centre. This reasoning is based on the firm belief that decisions taken in individual patient care are critical in determining both the effectiveness and the resource use of the health services. This delegation of decision-making authority to the clinical level is a prerequisite for good patient care; at the same time, the capacity to use it is in its nature a managerial characteristic.

Such extensive delegation of managerial responsibility within the health care system requires practical solutions different from those used in more purely hierarchical organizations. The consequence is that health care management, which tends to rely on theoretical concepts developed in industrial or military contexts, should actually pay more attention and effort to developing a theoretical base that is relevant for the uniqueness of health care institutions.

Health care management involves more than patient care managers at the clinical level and managers at the institutional or programme level, e.g., a

hospital director or an environmental programme administrator. At the level of total care, there is growing emphasis on comprehensive structured and integrated total health care systems. Moreover, such developments as regionalization, multihospital systems and the conflict of primary care levels versus secondary and tertiary care levels, all call for managerial capacities capable of dealing with complex multiorganizational systems. The three types of manager so far described – patient care managers, institutional managers and multiorganizational managers – can be placed on a continuum extending from patient interaction to the top administrative level of the health care system. Along that continuum, a mix of managerial generalists and specialists is required, with an increase of managerial specialists towards its upper end. Managerial specialists provide support to the general managers. For the management of a large complex health care system, specialists will be required in such fields as finance, planning, human resources development, organization development, legal aid, industrial relations, community relations, etc.

3. KEY ISSUES IN HEALTH SERVICES MANAGEMENT

Among the medical, social and administrative factors affecting the management of health services, the Working Group paid particular attention to the influence of public policy-making on service organizations and to the growing importance of involving physicians and nurses in management.

3.1 Public policy-making and health care management

It was pointed out at the Working Group that the task of managing health services organizations has become extremely complex and has to take place in increasingly more turbulent and conflictual environments.

Though managers may be able to cope with the complexities of their tasks and may be able to work in difficult political, professional and institutional environments, it is no longer enough to train them in management and information sciences, in budgeting and accounting skills or in public law and regulations that affect their own scope of activities only. What is equally, if not more, important is to prepare them in leadership skills to deal with highly competing professional and occupational groups inside a service organization, to make them sensitive to what organizations are all about, and to prepare them for the complex relations they will be involved in within and beyond their own organization.

There are managers whose reputations vary and who have different degrees of influence and power, depending on the resources they control, the skills they bring to their job, and the prestige the service organization has

in the overall health care system. The skills and techniques required to manage a large-sized multipurpose medical school or teaching hospital are patently very different from those needed to run a community health centre or to provide public health services

Irrespective of the different tasks and of the different organizational frameworks and patterns, there are some general developments which affect all types of health managers. These developments have to do with the influence of macropolitics and the effect of public policy-making on service organizations and consequently the organizational changes that have taken place and which affect health services management in different circumstances.

The health care sector is becoming an increasingly important service and employment sector. As health expenditure represents an increasing proportion of overall public expenditure, and as costs have soared, cost controls and other regulations have been imposed to stem the inflation. What has often been ignored are the effects which frequent policy changes have on service systems that have operated on the basis of well-established rules and of stable patterns of behavioural interaction between professional providers, administrators and service recipients. The frequent changes in legislation, regulations and rationalization, have affected the relationship between providers of a service and financial carriers, the relationships of service managers to providers and financial intermediaries, and also the relationships between service managers and different professional subgroups interacting in a single service organization. Following public policy-making in the health field, considerable changes have also taken place in the relationship between national governments and subnational authorities and between the public and the private sectors. The impact on many managers and providers of these changes in established patterns of interaction – not only of public and private organizations, but also of professional and occupational groups – has been turbulent indeed.

Government by contract and by delegation to private and quasiprivate groups and organizations is increasingly characteristic of the health care system in some countries and has blurred the lines between the public and the private sector. Nevertheless, there is a continued assumption that there are clear-cut dividing lines in health between public and private interests, between the public and the private sector and between public and private policies. The reality is different. The developments that have taken place make such distinction difficult despite certain academic, political and administrative arguments. Four examples will illustrate the increasing interdependence between public and private health interests.

Firstly, an increased interpenetration of the public sector by professional experts that sit on governmental advisory bodies and formulate public policy can be observed. But in health matters, this interpenetration is not unidirectional; there is considerable influence which the public sector exerts

on private organizations through regulations and controls that are increasing in scope and in numbers.

Secondly, there is the practice among government officials at different organizational levels of a health ministry or at different governmental levels responsible for certain health functions, to contract out responsibilities and research to private consulting firms, outside bodies or other private institutions.

Thirdly, theories of bureaucracies and bureaucratic behaviour have pointed to the importance of the relationship between those who have to enforce controls and their outside clients and beg the question who controls whom.

The fourth and last example refers to the increasing interdependence and interrelatedness of modern societies that use all kinds of organizations which relate simultaneously to different political influences, political actors and professional groups.

As shown by these four examples, the traditional theoretical distinction between the public and private health sectors (a distinction reinforced by certain traditions of public law and by perceptions on the relationship of society to the state) simply no longer holds empirically. The conclusion to be drawn for curriculum development is to expose future managers in health services to different theoretical approaches that explain such aspects of their activities, since they are likely to have to frequently cope with them.

Firstly, health service managers ought to be trained in normative theory or in value goals of what they ought to do, given their task and the decision alternatives they might have.

Secondly, health managers ought to be exposed to descriptive theory which explains the structures and workings of service organizations, including the relations that exist between a service organization and the larger environment.

Thirdly, they ought to be exposed to theories that provide a close understanding of different behavioural patterns of those who act inside organizations. Here, four different behavioural models of administrator have been developed in organizational theory: the rational model which assumes the administrator to be strictly a rational person, the sociopsychological model that assumes that decisions by managers are influenced by social-psychological factors, the cultural model which argues that service administrators are conditioned by cultural environments, and finally the behavioural model that says that managers are basically political actors.

Fourthly, future managers ought to be trained in instrumental theory, i.e., the type of theory that provides them with refined managerial techniques for efficient and effective performance.

The study of the general developments outlined earlier and the inclusion of these four different theoretical approaches can be important contributions by an empirically oriented political science and public administration to a

training programme for health services managers. There are other areas where the two subfields might be of great help to a better understanding of what is really happening in an organization or in policy developments, as opposed to what one thinks is happening.

Much public policy-making legislation and policy analysis is based on the assumption that there exists a rationally-organized process which secures and facilitates the coordination and implementation of legislative goals, preferences and priorities. Nowhere is the assumption more blind than in relation to the health services. This assumption has its roots in the theory of the separation of powers, in the notion of the supremacy of the legislature in policy formulation over the executive branch and in the subordination of administration to policy makers. But theories that treat administrative organizations, including health agencies, as neutral, rational servants and caretakers are static and inadequate in explaining what administrative organizations really are and do.

Rather, one needs to apply theories that treat organizations as living and dynamic institutions pursuing specialized and limited goals and which are complex human collectivities. Health organizations cannot be considered to be separate from a larger social and political context. They can only function if there is continuous interchange with the larger polity, if they dispose of resources, or finally, if other organizations do deliver goods and services. These remarks on characteristics of organizations may be obvious. However, many of the training programmes in the health field exclude the study of health organizations from their curriculum.

Not only should a training course in health services management include political science as well as organizational administrative theory, but it should also address the constitutional and legal settings – as well as the political and institutional frameworks that affect health policy formulation and implementation.

In addition, such a training programme should include the teaching of skills in policy analysis and policy evaluation as well. In so doing, health managers should be taught analytical skills, statistical methods, the use of computer techniques and economic cost/benefit analysis that make it possible for future service managers to manipulate a huge amount of information and data. Moreover, the teaching of policy analysis and evaluation should include the dynamics of politics, the ambivalent nature of most policy goals, and the dynamic interactions among the many actors and organizations involved in the implementation process.

Health service technocrats with no sensitivity to the influence of policy or of political and behavioural aspects are a disaster not only to providers and professional groups in a service organization, but above all to service recipients. Likewise, health service managers who have a solid understanding of organizational politics and the political effects of public policies on a service organization, but have no good management skills, are probably equally

bad for the entire organization. Thus, it is extremely important to teach the dynamics and ambivalence of policy goals and policy implementation that can counteract rational policy analysis and evaluation.

Training programmes to teach what health administration *ought* to be, instead of what it really *is* or what service managers *ought* to do, instead of what they really *can* do are missing an opportunity for preparing service managers for their jobs. Implementation largely depends on the functioning of multi-institutional, multiactor and multilevel implementation systems that already exist or that have to be set up nationally. For example, numerous recent laws on planning require such implementation networks.

Irrespective of the place occupied by health services managers in the health care system, they are part of such interorganizational and intraorganizational networks of implementation. For this reason, they need to be ready to cope with highly complex real-life situations.

There is an additional reason why theories of implementation ought to be included in a training programme. Health services managers, like managers in other services systems, are increasingly trapped by the consequences of wrong assumptions made by national policy-makers about the real world. For example, in most national programmes, subnational and local units and delivery systems are treated as if they were alike, in spite of the fact that their roles, outlook and decision-making power differ markedly. Moreover, subnational and local actors are assumed to respond uniformly to national programmes and policies. Insufficient attention is paid to the fact that differing organizational structure and political contexts make a difference for implementation. Those who have been involved either in developing theories or in the practice of implementation come to realize that:

(a) implementors differ, or can differ, in their response and receptivity to national initiatives, whether they are from public, quasipublic or private agencies;

(b) the particular profile of local or area-wide networks of involved actors has an influence on the implementation of national policy and the performance of a health programme; and

(c) such local and regional networks of implementation differ from programme to programme depending on methods of financing, regulations, and characteristics of clients and providers.

3.2 The managerial role of physicians

Several developments have affected the position and role of the physicians with regard to managerial functions and responsibilities. For a long time after the transition took place from individual practice to joint activities in a health service, whether primary-care group practice or hospital medical

staff, physicians continued with traditional methods of providing care. Thus they stressed prerogatives such as absolute control of patient's access to care, the financial rewards for care and referral – if indicated – to other colleagues. More and more, however, working in groups instead of in individual practice has shifted attention to medical staff organization. In the wake of the transition, issues of concern have come to include coordination with other health workers, reviews and audits of competence and effectiveness, efforts to guarantee personalized service, attempts to define the required technological equipment and the staff to use them, and collective bargaining for financial rewards. These brought a managerial dimension to the role of those physicians who are heads of teams, department heads or chiefs of advisory and other committees at the institutional, regional or national level and who are confronted with priorities regarding the planning, the organization, the financing etc., of health care.

Another development affecting the managerial role of physicians in the health care system is the introduction of so-called "participatory management". In this, the workers and clients of an organization are brought into the management of the organization, which is no longer seen as being managed solely by a separate group of executives or by a board of governors. As the key health workers, physicians have an important role to play through their representatives in the participatory management system.

However, traditional medical education does not prepare physicians or other health personnel for such managerial roles. On the contrary, in traditional medical education, self-centred behaviour and related value-systems and attitudes are stressed, making it difficult to acquire a managerial perspective and broad outlook on, or appreciation of, organizational constraints.

3.3 The need for improved nursing management

In nursing, too, evidence of a dynamic, fluid and progressive climate of development surrounds us. Changing roles, re-evaluation of traditional practices, re-examination of the way personnel are utilized, increased specialization, consumer dissatisfaction, and a variety of care patterns are only a few of the factors calling for reorganization in the delivery of nursing care. The basic issue is the need for more effective utilization of all members of the health professions, particularly nursing personnel. If patients are to receive the care to which they are entitled, the primary care role of nursing must be revitalized.

Some of the problems in nursing management are caused by the unique features of nursing practice. For instance, a hospital has patients under care 24 hours a day, 7 days a week. Babies must be delivered at all hours of the night. Accidents occur at any time and the victims must be treated. Emergency surgical operations must be performed when needed, and, of course, hospital units must be adequately staffed and ready to offer their services at any time. These and other factors create tremendous problems for nursing management.

Nursing is predominantly a woman's profession and in some countries there are no male nurses. Young mothers work shorter shifts with specific requirements for duty time, according to the needs of their families. They also have long maternity leaves, and high rates of absenteeism are experienced.

The rotating shift-work presents another problem to nursing management. Very few nurses prefer to work evening and night shifts. According to a joint report on conditions of work by ILO/WHO (*2*), night work and the shift system are among the factors causing the most crucial problems in nursing services throughout the world. Moreover, according to the same report, the responsibility that they have for human lives produces physical exhaustion and nervous tension among nursing staff.

The turnover of nursing personnel presents another serious problem to nursing management. The more rapid and constant the turnover, especially of qualified nurses, the more serious the problem. It is estimated that more than 50% of all qualified nurses are inactive professionally.

This high turnover costs the health services heavily in recruiting and selecting and socializing replacements; and in overpayment of the replacement during learning when she cannot produce at full capacity. Therefore, nursing turnover increases the cost of delivering health services. Available data show that compared to other groups of professional women, nurses are generally less active in their profession. The low level of job satisfaction experienced by nurses may contribute to the greater inactivity rate among this category of health professionals. Regardless of the setting, the more an employee is satisfied with his or her job, the more likely he or she is to stay in that job. Available data suggest that many professional nurses are underutilized, and that their expectations are not met. The task of nursing education, to endow nurses with the skills they will need, is linked to the responsibility of active nursing service, i.e., to give them the opportunity to function properly and use what they know. The role of nursing management is therefore crucial. Nursing educators can prepare nurses by the thousands, and personnel managers can develop the most attractive benefit packages; but unless nursing management wrestles with the basic causes of dissatisfaction, nurses will continue to leave their jobs, and the problem of high turnover will remain unresolved.

Beyond the above-mentioned problems, nursing management must be based on a philosophy reflecting the belief in the worth and dignity of the individual served. Nursing management is responsible for providing all persons seeking nursing services with the highest attainable quality of nursing care. The concepts and criteria it should be based upon include the following.

(a) People are nursing's most important asset. This is especially true in health care, which actually and primarily consists of people caring for other people, though other assets such as finances, facilities and

equipment may be essential. This humanistic philosophy of management, which recognizes the dignity and potential of all individuals, is fundamental to the effective utilization of nursing staff.

(b) Conscious attention to management functions – planning, organizing, directing, controlling – is of enormous importance.

(c) Management by objectives must be adapted to suit all levels of nursing management.

(d) Clear definition of roles, delineation of responsibilities and organizational relationships are closely linked to the question of objectives.

(e) Leadership personnel must be selected for their skills in listening, problem-solving, decision-making, communicating, training, discussion-leading, perceiving and motivating.

(f) The example set by the nurse-manager has a profound influence on the attitude and performance of others.

(g) When invidivual needs are met by work experience, personnel are likely to be more highly motivated on the job.

4. MANAGEMENT EDUCATION IN THE EUROPEAN REGION

The current situation of education for health management in Europe is not so well documented as in some other regions of the world.[a]

The latest survey for the European Region dates from 1973. It identified a total of 25 programmes in 15 countries in Europe (*3*).

In 1977, the European Association of Programmes in Health Services Studies undertook a follow-up study by addressing an up-dated questionnaire to the respondents of the 1972 survey. Preliminary findings of this survey were presented to the Working Group. New programmes in Norway, Switzerland and Finland were named.

In the last survey, however, information is missing on most of the programmes in eastern Europe, on the majority of programmes in community

[a] In the Americas, the Kellogg Foundation has repeatedly sponsored surveys on the status of graduate and undergraduate education for health management. A recent survey (*3*) indicates the existence in the US and Canada of 72 graduate programmes in 1973. In the US there were 130 undergraduate programmes in health administration in 1976. A recent PAHO/WHO survey, also sponsored by the Kellogg Foundation, shows that in 1977 there were 60 graduate and undergraduate programmes in Latin America (*4*).

medicine in the United Kingdom, on programmes in Greece and probably on other programmes not identified during the Working Group. Relevant findings, thus, only relate to a comparison of programmes reported in both the 1972 and 1977 surveys.

There is still a great variation in course content, and in methodology and training emphasis from institute to institute and from country to country. Some of the variation undoubtedly reflects different educational philosophies, different cultural influences and differences in available resources. However, there should be room for some reduction in the scale of variation, especially for programmes having similar objectives. It therefore seems that very little progress, if any, has been made on this front during the past five years.

While there has been a scarcity of resources available to programmes in most countries, especially in the last couple of years, most programmes have enlarged their scope, incorporating in their courses other aspects of health care in addition to the institutional ones. Some have also made significant advances in research and development. Virtually all programmes, however, are still far from being able to integrate all disciplines relevant to health service management in joint full-time effort to develop a systematic body of knowledge. More funds and other resources seem to be needed to enable this to be done. In view of the increasing importance of health care in the various national economies it would appear to be a short-sighted policy for governments to continue to deny the funding needed for this purpose.

In countries where several programmes exist, there is no direct evidence that careful examination has been given to their joint potential. However, there have been information exchanges and also some individual, but rather isolated, instances of closer working relationships between institutions running programmes in different countries. These have mainly come about through joint membership in organizations like the European Association of Programmes in Health Services Studies. The Working Group felt that in this direction there still was substantial scope for improvement.

Greater priority now seems to be given to programmes of medical care and of health services management than to institutional aspects of health care and hospital management problems, a change of emphasis when compared to earlier findings. While there has been an increase in the amount of research undertaken by these programmes, there is little or no evidence to show that such research has given priority to the problem of how to shift the emphasis towards health services and away from hospital affairs.

The Working Group felt that some progress seems to have been made towards providing faculty teaching staffs with a thorough training in health services management, health economics, etc., but that there is still much leeway to be made up by most programmes.

5. DEVELOPMENT OF MANAGEMENT EDUCATION PROGRAMMES FOR HEALTH SERVICES

Before developing management education programmes in a given country some effort should be spent at national level to define a number of principles on which the resultant national strategy and every effort should be based.

The Working Group suggested that a series of basic and explicit principles should underly each effort regarding the development of education in health services management:

- education and training in health care management should be a continuous process and not a unique educational experience;
- this continuous process should be related to needs at successive key stages in career development;
- educational programmes should embrace all health workers with managerial responsibilities at different levels or from different disciplinary backgrounds;
- health agencies should be involved in the identification of training needs and in the development of educational programmes;
- basic programmes should be provided for those entering health service management and advanced programmes (both degree and continuing education programmes) should be available for practising managers: these programmes may include full-time, part-time and correspondence courses;
- a network of links should be established to permit management education to relate to both service agencies and their organization development and to health services research;
- the educational strategy should promote career mobility and should offer rewards and career incentives to those individuals investing in continuing education and management development.

The Working Group stressed that management training can be offered in quite different settings and under different formats, and that one should not keep to a single model.

Established institutions, such as universities, independent educational institutes, staff colleges, etc., can offer courses on a continuing or a modular basis. The latter format can be combined with the job requirements of practising managers or health professionals. On-the-job education and in-service training programmes offer the advantage of appropriate and highly relevant learning environments in the true environment of the management function. Correspondence courses, however, require substantial and rigorous supervision.

The curriculum content of management education programmes will depend on the type and format of the educational exercise and on the level and managerial responsibilities of the students. The Working Group felt that ignoring the management potential of established categories of health workers and building educational curricula from a zero-base line incurs the risk of an excessive proliferation of new occupations in the health sector. Due consideration should be given to a reallocation of functions among existing occupations in health care, aided by adjusted management curricula.

In designing a particular curriculum, skills, techniques and knowledge should be fully mastered. For know-how, on the other hand, an appreciation should suffice. For instance particular numerical skills or techniques in epidemiology, operations research, economics, statistical analysis are not required from all types of managers. An appreciation of the contributions and indications of inputs of political science, economics, epidemiology, etc., may be sufficient as educational objectives for general managers. On the other hand behavioural skills are essential, and skills in communication, negotiation and group interaction are crucial for all levels and types of managers.

Curriculum content should also be weighted as regards emphasis on either general management or on a managerial specialty. The main effort should, in the opinion of the Working Group, be slanted toward the development of managerial generalists with a specialist option, thereby providing in the curriculum for an orientation-module in a given specialty.

Taking the above into account, the relevant subject areas for management education were considered to be the following.

- *Health, disease and care-processes,* focusing on need and demand for care and their service and resource equivalents; to be approached from the biological, mental, social, political and ecological standpoints, and to include inputs from disciplines such as epidemiology, medicine, marketing, demography, ecology, anthropology, medical sociology and political science.
- *Health care systems,* relating to the central features of the planning, organization, financing, regulation and evaluation of alternative organizational modes of health services delivery, with inputs from systems theory, health planning, health law, social security law, labour law, bioethics, industrial psychology, organization theory, interorganization theory, evaluation theory, political science and sociology.
- *Quantitative analysis and management control,* providing the analytical and evaluative tools required for managerial performance; to include inputs from fields such as epidemiology, biostatistics, management techniques, accounting, microeconomics, industrial engineering, operations research, psychology and sociology, computer

science; and to develop the appropriate insights and skills to understand and analyse the economic aspects of the health care system and the political processes affecting it, based on such disciplines as economics and political science.

- *Communications*, providing skills in effective interpersonal, intra-organizational and external communication, and based on such disciplines as psychology, sociology, political science, anthropology and health education.

The transfer of knowledge, attitudes and skills with respect to the above subject areas should not be based only on formal education in educational settings. It involves practice settings and such important activities as organization development and health services research from which students and trainees cannot only profit, but to which they can also contribute.

It was repeatedly underlined that such important matters as the design of courses, the selection of trainees, the commissioning of educational and/or practice settings, or the evaluation of educational performance, should not be left to either the educators or the practice field alone.

Given the state of the art of health management sciences and the extremely limited teaching staff resources allegedly available in the European Region, it seems important to gear the management education efforts to the real problems in the field. Thus, one should refrain from unrealistic educational objectives and maintain a constant concern for feasibility.

6. HEALTH MANAGEMENT EDUCATION AND HEALTH SERVICES RESEARCH

In any plans for developing education in health management, the element to be devoted to health services research should not be neglected, it was felt by the Working Group. At the same time as definitions are needed to hold this element within reasonable bounds, a precise definition of health services research is difficult to find. Health services research is concerned with problems in the organization, staffing, financing, utilization and evaluation of health services. Biomedical research, with its emphasis on normal and pathological structures and processes in human beings (and its reliance on disciplines like biochemistry, biophysics, physiology, microbiology, cell-biology, genetics, immunology, etc.) is not usually included in the concept of health services research, although borderline cases exist. Health services research is primarily concerned with the effectiveness of medical care. Effectiveness of medical care is consistent with its accessibility, availability, its quality and its efficiency. So these factors are prime issues in health services research.

Of relevance to the effectiveness of medical care in this broad meaning are, on the one hand, health beliefs and health practices of consumers of health care, and on the other, the planning, production, deployment, organization, financing, management, and evaluation of health care services. Health services research can be classified in various ways (see Fig. 2). In a time frame, one distinguishes retrospective from prospective research; by research method, research can be divided into experimental or nonexperimental research (the latter being either descriptive/analytical, comparative or historical) and depending on purpose, it can be classified under basic, developmental and applications-oriented research.

Thus, health services research is highly relevant for health management education, and it provides the theoretical base for the latter. The Working Group identified two strategies which might be employed to provide organic links between health management education and health services research.

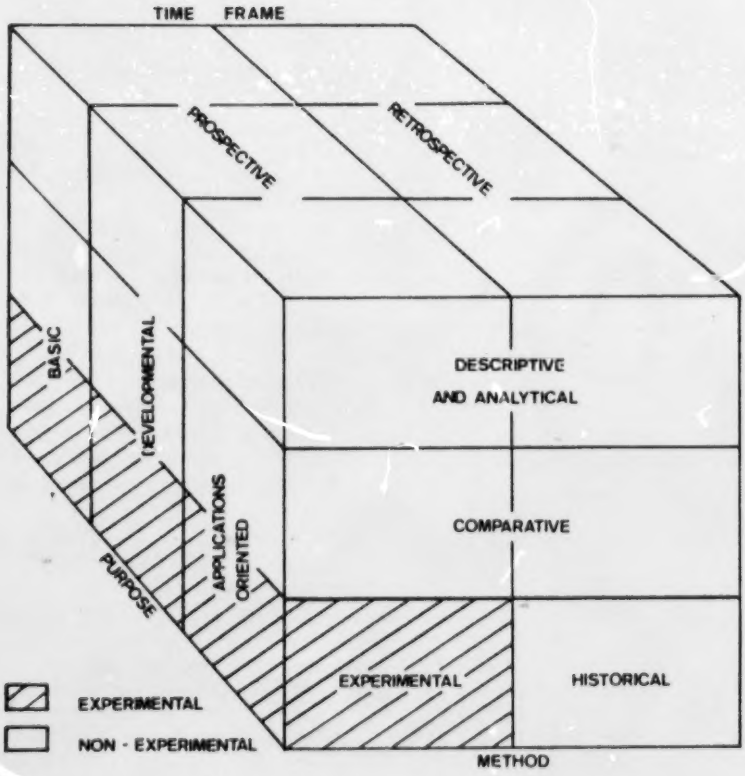
A first strategy can view health services research as the pinnacle of a management education programme. This means that all resources are first concentrated on teachers and education, and only when educational programmes are well established will resources be devoted to such activities as consultation, community service, organization development, doctoral preparation of teachers and scholars and, ultimately, health services research.

Another strategy is to see health services research from the start as a core function, providing content for basic programmes and for continuing education in health services management. In this way, health services research would respond to the organizational problems of the health agencies, adjust the research agenda to the needs of the health care system, receive resources from the health care field, etc.

Both strategies depend on a number of prerequisites:

- health services research is essentially multidisciplinary and calls for inputs from such disciplines as economics, sociology, epidemiology, operations research, political science, health law, nursing, medical care organization, public health, industrial psychology, ethics, etc.;
- health services research depends on a substantial data base, and unless this is routinely available and accessible, scarce resources will have to be spent on data collection, with little room being left for analysis;
- health services research should relate to field laboratories willing to experiment and to support pilot studies, model-building, demonstrations and rigorous evaluation;
- research sponsors should allow for researchers to obtain career stability and provide an organizational memory in respect of research objectives and performance;

Fig. 2. Classification of health services research by method, purpose and time frame[a]



[a] **World Health Organization.** *Report of Consultation on the International Programme for Training in Health Management*. Geneva, 1977 (mimeographed document HMD/MSD 77.10)

- a monitoring system should function to ensure the quality (soundness) and relevance (social impact) of health services research: special attention should be paid to the methodological and feasibility aspects of research designs and protocols, and to the special managerial constraints of health services research;
- health services research should be made more visible, providing a separate entry in research inventories used for national research, in expenditures and in budgets;
- adequate financial resources should be made available for health services research;
- special attention should be paid to the borderline between biomedical and health services research and to the credibility of the latter among the medical community;
- responsibility for the implementation of health services research findings should be clearly delineated and, preferably, should be shared by customers and the providers of research.

The Working Group endorsed the second alternative which uses health services research as the continuous primer of health management education.

7. PROMOTION OF NATIONAL MANAGEMENT EDUCATION PROGRAMMES AND ROLE OF INTERNATIONAL COLLABORATION

Prerequisites

The promotion of national health management education programmes depends in the first place on an explicit national health policy, aimed at solving the problems of health and ill-health by including management as an important aspect and dimension of health services. Such an explicit national policy should identify those responsible for the education and training of managers for the health services.

In the second place the involvement in, and commitment to, sound application of management principles at the highest echelons of a nation's health authorities will help strengthen the awareness of health professions concerning the need for, and importance of, proper education and training in health care management.

Thirdly, the institutionalization of health services research activities, preferably combined with institutionalization of education and training of managers in the health services, will be potent adjuvants in the promotion of national management education programmes.

In the fourth place, any promotion of education and training programmes for managers in health services will be determined by the availability and quality of teachers in management and scholars in health services research. In many cases, teacher training and the preparation of properly trained researchers will be the first priority in the development of a national management education programme.

Lastly, special attention should be given to adapting publications and teaching aids, available in the field of management, to general and health care management, with particular concern for the national context and national needs. National and international collaboration is seen as an important activity in bringing countries to a higher level of performance in health management education. In addition to WHO, other international and national organizations of either governmental or a professional nature are engaged in such collaborative efforts. The Working Group identified some examples:

(1) European Association of Programmes in Health Services Studies;

(2) Association of Schools of Public Health of the European Region;

(3) International Epidemiological Association;

(4) International Hospital Federation;

(5) Association of University Programs in Health Services Administration;

(6) Health Commission, CMEA;

(7) European Association of Hospital Administrators;

(8) European Public Health Committee, Council of Europe

8. RECOMMENDATIONS

The Working Group, in formulating its conclusions, focused on the need for cooperation within and among countries. It recommended in particular the following:

8.1 At the national level

(a) to strengthen educational programmes in health management and make them an explicit part of national policy, through firm links between health management education, national health planning (using methods such as country health programming) and health services research;

(b) to consolidate and rationalize overlapping efforts in health management education, thereby linking individual programmes in an integrated national network;

(c) to develop projects in such areas as profiles of management education of health care managers, curriculum content and teaching aids, educational methods, staffing of health management education, evaluation tools and relevant research management and methodology;

(d) to launch staff workshops/national seminars – for different professional groups with the potential to contribute to health care management – on the subject of health management education, thereby also increasing the pool of visible resource persons;

(e) to consider initiatives to make health care management a challenging and rewarding career in order to attract talented individuals to the field;

(f) to consider machinery (pooling included) to ensure that potential users of advanced teaching aids have access to them less expensively than at present.

8.2 At the international level

(a) to identify an organization prepared to act as a European clearing house on developments in health management education, opportunities for staff development, relevant publications, etc., as well as to develop a staff directory for Europe listing teaching personnel by subject, research activities, and languages spoken. This information should be circulated regularly to programmes and interested individuals;

(b) to establish a list of resource persons in health management education on whom countries and WHO could call as advisers or visiting lecturers to help improve such programmes; and, finally,

(c) to advise national fellowships programmes that management training is a desirable priority area for awarding WHO and other fellowships, in order to prepare solid educators in health management.

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Annex I

HEALTH MANAGEMENT EDUCATION AND TRAINING

Professor J.E. Blanpain[a]

1. Introduction

This paper identifies the major characteristics of current efforts in health management training. It reflects on the recent changes in society and in the health care system that call for a different emphasis in health management and new inputs in education and training for health care management. A typology of health care managers and a model for national self-reliance in health management education and training are presented.

In principle, four types of activity can be distinguished: management education, management training, management development and organization development (*3*).

Management education aims at providing relevant knowledge, attitudes and skills to permit managers to perform successfully a large variety of tasks in various organizational situations and settings.

Management training is more organization-specific and is intended to prepare people for well-defined jobs by developing skills immediately useful for well-known tasks and assignments.

Management development is intended to enhance the managerial performance of practising managers through a variety of job-related educational activities within a policy of continuing education.

Organization development aims at improving relationships, communication, functioning of teams, etc., within organizations so that the transfer from what the individual managers have learned to improved organizational performance can be synchronized.

2. Current trends in management education programmes in Europe

Programmes in health management training were established in several European countries around 1960, more than 30 years later than comparable initiatives in North America (*1*). A survey made by the author in 1970 indicated that at that time 15 countries in the European Region of WHO had one or more programmes, with a total of 25 institutions, that met the definition of "being devoted to training in hospital and health services

[a] Director, Department of Hospital Administration and Medical Care Organization, University of Leuven, Louvain, Belgium

administration and based on a permanent and identifiable core of activities and resources and which are situated in settings primarily devoted to education" (*2*).

The majority of the European health management training programmes can trace the rationale for their creation back to the preoccupation with hospital efficiency which characterized the immediate post-World War II period. It was then argued that the hospital was eventually to become the centre-piece in the delivery of health care. The increasing complexity of hospital functions, the rising costs of hospital care, the growing dependence upon public financing or third-party payment and the prevailing philosophy of a hospital-based health care system were used as arguments for paying more attention to hospital management as a leverage towards more efficient hospital organization and operation. This basic outlook was reflected in the main orientations of the programmes which were created in Europe from 1958 onwards to train people to cope with hospital problems.

A first characteristic of the majority of the programmes is to concentrate on training in the spectrum of possible activities aimed at improving the performance of organizations. Most of the current programmes in hospital and/or health services administration are still primarily training-oriented, preparing people for more or less well-defined positions. Few, if any, programmes have risen to the level of management education. Only a limited number are involved in management development and organization development.

A second characteristic of most current programmes is their dominant interest in hospitals, in particular, general short-term hospitals, and hospital matters, with emphasis on legal aspects, accounting, personnel administration, industrial relations, plant management, etc., within a short-term perspective of day-to-day management. Only token attention is given in most programmes to the broader health care system or to managerial tasks with a longer time perspective such as corporate planning, initiating change, assessment of social impact, etc.

A third characteristic of the existing training programmes is their dependence on concepts, theory, methods and techniques which were primarily developed within industrial and/or military contexts. This body of knowledge is not necessarily appropriate or intended to deal with services which differ so fundamentally from commerce, industry, the army, etc. Some of these fundamental differences are found in the intangible, rarely explicit, open-ended objectives of health services, the labour-intensive and talent-intensive nature of health services, the autonomy of health workers, the passive role of health service clients, etc.

A case in point was the indiscriminate transfer some years ago of PPBS (Planning Programming Budgeting System) from the military establishment to health services. What had been developed as a management tool for capital-intensive, closed and authoritarian military systems with well-defined and

quantifiable goals and objectives proved not to function for open, labour-intensive, nonauthoritarian social systems with ill-defined goals and objectives (*4*).

A fourth characteristic of health management training programmes is their tendency to develop so-called "lay managers". Reluctance to prepare health professionals (doctors, nurses, etc.) for managerial roles is rationalized on the grounds that "one should not waste those long years of education as health professionals". A more subtle reason is the avoidance of conflicts of interest which, it is claimed, are bound to arise between managerial responsibility and direct patient care responsibility.

A fifth aspect, typical for most efforts in health management training in Europe, is the preference for middle-level, general management (e.g., hospital directors). Little attention is given either to top-level or senior management or to the need of the health care system for so-called managerial specialists, e.g., health planners, finance officers, personnel managers, specialists in industrial relations, computer specialists, systems analysts, etc.

3. New challenges for health care management

Since the beginning of the nineteen-sixties, when most of the current training programmes in health services management were launched, major changes have occurred in society in general and in health care in particular that require fundamental shifts in the scope, emphasis and content of health care management and the training for it.

The early 'sixties witnessed a series of initiatives throughout Europe to achieve a solution (mainly an institutional one, inspired by the hospital-centred philosophy of the future health care system) to problems regarding the aged, the chronic sick, the mentally ill, the mentally retarded, etc. These initiatives resulted in such piecemeal action that it rapidly led to the conviction that a more systematic approach was needed. Blueprints and plans for comprehensive, structured and integrated total health care systems were developed and their implementation began (*5*). The hospital-centred philosophy gradually gave way to a more even view of the health care system whereby primary ambulant care and preventive services received increasing attention, or at least a great deal of lip-service.

Considerations of cost/effectiveness were fundamental in these developments. Paradoxically, the enormous cost explosion in health care since the Second World War has not been accompanied by impressive improvements in life-expectancy or by drastic falls in morbidity levels. In fact, life expectancy for adults lately seems to be slightly on the decrease (*6*). The effectiveness of health care and its impact on the quality of life and on life expectancy is no longer an unquestioned article of faith. Suddenly it has become a vital and contraversial issue (*7, 8, 9*).

Hospitals are considered by many to provide cost-ineffective answers to a very considerable part of their current workload, which may either fall within the scope of ambulant care at the primary care level or be the direct personal responsibility (through self-care and self-reliance) of the individuals concerned.

These major mutations in the health care system have already been expressed in blueprints and in national health care goals and plans. However, for their implementation, they require far-reaching changes and are dependent on a number of prerequisites. These include data and information on the health status of the population, assessment of the cost/effectiveness of alternative modes of health care delivery, data and information on existing and future health resources and, last but not least, managerial resources to effect the desired changes in the system, both at the strategic level and at the operational level.

The increased importance attached to planning gives to managers at all levels of health services management a clear responsibility for knowing the overall goals, objectives and targets of the organization, for ensuring that subordinates know these as well and understand their implication for the daily operation of services, and for ensuring that the work is done accordingly.

Complicating this situation is the increasing specialization among health professionals. This creates the need for a team approach to patient care and replaces the traditional hierarchical management model with less clear structures. Closely linked to this problem are the leadership duties which relate to the promotion of cooperation between units and to motivation for good working performance among subordinates. This faces health service managers at different levels of management with new problems; hence they should be properly educated to resolve them.

The situation described so far is further complicated both by the prolonged economic crisis and by the prevailing tendency towards zero growth, "sobering up" and casting doubt on progress *per se*. Growth models in health care, plans for costly health facilities development and the belief that there is a shortage of health manpower are being replaced by constraint models, by goals to limit hospital facilities and by prospects of a manpower glut. A provider community, for decades secure in its position as a privileged and unchallenged partner of government in a joint venture for health "at any cost", has to be relocated and redefined as to its appropriate role and relationships in a "health at reasonable cost" approach, even at the risk of the professions concerned losing their privileged status.

Changes in the political-administrative sphere also affect the health care system. Two developments have major consequences. The first pertains to the gradual shifts in the seats of political-administrative power. The power of the nation-state is gradually but continuously being eroded in two directions: upwards to the supranational level and downwards to a subnational level. At the same time, local authorities are being reorganized and

concentrated to relate more closely to the strengthened subnational level. Current trends in the member countries of the European Economic Community illustrate such development.

The emerging structured and comprehensive health care system tends to be viewed as territorial, regionalized and more or less coterminous with the reorganized local authorities and subnational authorities. This alignment itself is difficult, particularly in countries where the restructuring of health care provision on a territorial basis within a pyramidal structure, guided by a degree of specialization, present considerable problems (*10*) because of the fact that the majority of hospitals were allowed for too long to develop towards the same level of specialization.

Guiding such dynamic and complicated developments of the health care system during a transition period, when political power is being relocated and administrative structures are being realigned, demands a serious effort in interfacing the health care system with the broader systemic environment. It also calls for health services research and development, health policy analysis, demonstration projects, health planning, development of information systems, allocation and reallocation of health resources, health resources development activities, evaluative studies, etc. In all these efforts, management has to play a key role and exercise a leadership function.

A second major development in the sociopolitical sphere is the increasing importance of the "fourth power". The classic separation of powers along the Montesquieu model, namely the legislative, executive and judiciary powers, is now confronted with the emergence and consolidation of a fourth power: the interest groups. These intervene in particular in the legislative process and interfere in the actions of the executive power.

Health, education, the environment, energy, transport and the media are all domains in which professional groups, academics, unions, consumer representatives, ecology groups, etc., can bypass, erode, counter or outwit the traditional and formally elected or appointed bodies of society in such areas as policy formulation, the establishment of priorities, resource allocation, the determination of social rewards and distributive justice. Health services management is affected by this change to the extent that a keen sense and a thorough understanding of the way the "fourth power" operates, together with a sufficient grasp of overall sociopolitical dynamics, is a prerequisite for the health care manager.

A change along similar lines has occurred in organizations, including health care organizations. The traditional three-level decision-making structure: (1) policy-setting board, (2) executive management, (3) operations level, is confronted in a participative management philosophy with a situation in which the workers of the organization on the one hand and the clients of the organization on the other are involved in the decision-making process. Personnel representatives, in particular physicians, move into advisory capacity positions and even into direct trustee or executive management

positions. Managerial responsibility is handed down to staff at the operational level. The move towards including patient representatives on administrative boards or advisory committees and even the stress on patient self-reliance can be seen as parts of the same trend to reshape management towards better satisfying the interests of all the participants in the organization. This calls for totally different management styles, for improved communication and bargaining skills and for a redefined role of health professionals in managerial responsibilities for which they must be properly prepared.

On the basis of these different developments it would appear that planning, coordination, stimulation, evaluation (critical analysis) and control are basic management functions of primary relevance to educational programmes in health services management.

4. New inputs in health management education and training

The important changes which have occurred in the health care system and the resulting challenges facing the health care manager indicate an urgent need to introduce new disciplines in the curriculum for health care management education and training.

A first essential is to raise epidemiology to the status of a fundamental science in the curriculum and in the practice of health management. Organizing health services on the basis of the needs of the population instead of on the basis of available resources requires an epidemiological outlook whereby the population as the numerator in the ratio of services to be provided becomes the focus of attention, incidents and episodes of care are replaced by cases treated, and services rendered are replaced by individuals cared for (*11*). The delivery of health care under cost/effective conditions demands systematic appraisal and evaluation, to which epidemiology can make an enormous contribution (*12*). Areas in which epidemiology can help the health care manager include disease etiology and assessment of the efficacy, effectiveness and efficiency of health service interventions (*13*).

A second important new input in management education and training is political science. The fields of sociology and economy which are already fairly well represented in the current curricula should be enlarged to include political sociology and political economy. An understanding of the dynamics, the forces at work, the structures and persons involved, the underlying ideologies of the political processes and the economic decision-making, and the resulting social and economic policies, should become an important ingredient in the education of health care managers. Case studies are available in abundance to illustrate and document the importance of polity and politics in health (*14, 15*).

Interorganizational theory is a third type of new input which is badly needed in the preparation of those expected to help create and operate integrated comprehensive multiunit systems (*16*). Traditionally, the behavioural

sciences' inputs in the management curriculum have focused on individual and group dimensions at the intraorganizational level. However, linking and merging several organizations into larger supraorganizations which health care systems are, brings in a third crucially important dimension, namely the interorganizational level. The limited study of the legal, financial, psychosocial, ethical and other aspects of this interorganizational level is at odds with the rapid pace and intensity at which interorganizational systems in health care are being established or experimented with. Although attention was paid in the 1974 reorganization of the National Health Service in Great Britain to the issue of interorganizational dynamics, the Service is still feeling the effects of the ambitious merger of the previous tripartite system (*17*). Another example of the importance of interorganizational theory is the fact that in the USA in 1976 as many as 30% of all hospital beds were provided through so-called multiunit hospital systems (*18*). Moreover, all the national health care plans in Europe provide for collaborative arrangements to the point of physical mergers of previously independent organizations. "Coordination", "cooperation", "comprehensiveness", "planning", "regulation", "regionalization", all these are only slightly more specific directional terms for the same generic phenomenon: interorganizational activities for which the health manager must be duly trained.

A fourth major domain deserving more emphasis in the management curriculum is the core function of the health service: "care", its variants and the underlying decision-making by both the receivers and the providers of care (*19*). Managerial interest and attention in health services have concentrated their efforts too long on marginal phenomena like catering, linen service, housekeeping, accounting, plant management, etc., while there has been a certain benign neglect of the basic managerial mandate, to influence the behaviour of recipients and providers of care towards optimizing care processes and, ultimately, the outcomes of those processes. The intimate patient-doctor relationship is responsible for this "permissive" approach. The confidential nature and the trust relationship which are conducive to humane and effective patient-provider interaction tend to divide the terms and the processes of such encounters into isolated phenomena which are left to the discretion of the individual provider who resents managerial interference. The autonomy of health professionals in this situation makes it difficult to consider aspects such as indications for and the effectiveness and efficiency of health care interventions.

It is at least advisable that the health manager should understand the motives, attitudes, values and expectations underlying both patient behaviour and provider behaviour. Moreover, having a keen insight into the actual decision-making and the premises and logic of physicians, nurses and other health workers while they are caring for patients is crucial before one can attempt to influence that decision-making.

When such decision-making was taken for granted and went mostly unquestioned, there were few incentives to know more about it. Nowadays there is controversy over costly medical interventions, e.g., coronary by-pass surgery, which presents drastically different options in resource commitments, depending on the sides taken in the controversy.

New technologies are being announced, like third-generation computerized axial tomographs or neutron guns which could lead to staggering expenditures in investment costs and particularly in operating costs, depending on the assessments made as to the indications for use (*20*). There is in a number of countries, especially in North America, a growing problem of malpractice litigation.

All these developments call for managerial decisions that interfere with professional decision-making. Unfortunately, medical decision-making has received little attention as a phenomenon for investigation and study, so that relevant inputs to management education will depend on an intensified study effort in this respect.

5. Types of health manager

Not only should efforts in health management education and training draw on new scientific disciplines and incorporate their theory and findings in the curriculum, but a broader mix of managerial inputs should be made available beyond the current emphasis on the middle-management generalist.

Comprehensive health care systems need two main categories of managers: general and specialist.

5.1 General managers

Three subgroups may be distinguished.

(a) *Senior managers* at the interorganizational level or at the intermediate level in area systems. They supervise the development of a multi-unit organization with effective public, provider, consumer and political representation capable of bringing together the agencies and elements of the existing health services system in the direction of cooperative and innovative change. They analyse and interpret problems in the delivery of services, develop strategies and mobilize resources necessary for programme developments; recommend budget priorities; coordinate action in health care, education and research.

(b) *Middle-level managers* at the institutional or programme level, responsible for the planning, organization and evaluation of the operations of their institution or programmes within the framework of the overall system.

(c) *Unit managers* responsible for the day-to-day operation of departments of institutions or components of programmes.

5.2 Managerial specialists

This category of personnel provides support to the general managers. Such specialists represent fields such as fiscal management, industrial relations, personnel management, systems analysis, human resources management, materials management, plant engineering, health planning, data processing, health law, project management, operations research, public relations, security, safety, food management, marketing, medical information, social insurance, statistics.

Multiple scenarios combining different mixes of education, training, continuing education and organization development can be contemplated for preparing the four types of managers described above, who are, in fact, in existence to some extent throughout the world.

Key issues to be considered in defining a national management education strategy are: Is senior health management reserved for promotion from within, or is it open to outsiders? Is mid-career training considered as an adjuvant and seen to provide access to senior management? Is senior management accessible directly after university graduation? Are given managerial positions reserved for holders of specific degrees, e.g., in medicine, health or law? Are executive management positions occupied on the basis of promotion or on the basis of a degree? Are posts in unit management preferably occupied by health professionals? Do career structures and their constraints, such as financial rewards, pension rights, etc., permit flexibility or do they tend to create rigidity?

Answers to these questions differ from country to country and are influenced by a number of assumptions and biases concerning health administration. Health management is not different from other fields of management and does not justify a special education effort. There is insufficient evidence that a given combination of formal education, training and experience is more successful in preparing health managers. There are more effective managerial decisions taken in health care by individuals with no formal preparation in health management than by trained managers. The professionalization of health administration may be counter-productive in creating another group, adding the adverse effects of professionalism to a field already plagued by a myriad of entrenched professions (*21*).

6. A national model of health management education

In view of the above, it seems that a standard formula applicable everywhere for national self-reliance in health management education is not practical. However, a number of principles can be identified to guide the formulation of a national model of health management education:

- the approach should aim at a continuous process of education, training and development instead of concentrating on a single educational experience;

- the educational efforts should span all workers with managerial responsibilities in the health care system;
- the strategy should promote career mobility;
- rewards and incentives should be built in to stimulate individuals to continue education and management development;
- provision should be made to balance educational efforts between practising managers and those preparing to become managers;
- provisions should be made to accommodate students in respect of constraints of time and/or distance, e.g., part-time study, correspondence courses;
- educational efforts should rely on, and interrelate as much as possible with, health services research and development.

With respect to the above principles, four basic and interrelated approaches are suggested as foundation stones for creating a national capacity in health management education and training.

6.1 An academic degree programme

This should preferably be conceived as a multidisciplinary programme within an educational setting, offering at graduate or postgraduate level the following educational experiences.

(a) A full-time postbasic academic programme for students in residence who may or may not have had previous health professional training. Several variants are conceivable, of which one or more may be available in the same setting:

- degree in management with personal services orientation,
- degree in management with health services orientation,
- degree in management with health resources planning orientation,
- degree in management with public health practice orientation,
- degree in management with nursing orientation.

It is possible to build these variants around a common core on the basis of credits providing knowledge, skills and attitudes basic to specialization in any of the various areas of health administration and also permitting, through a common educational experience, more effective communication among future specialized health managers.

The common core should focus on the following areas:

- *health, disease and care-processes* focusing on need and demand for care and their service and resource equivalents, approached from biological, mental, social and ecological perspectives and with inputs from disciplines such as epidemiology, medicine, demography, ecology, anthropology, medical sociology and political science;

- *health care systems* relating to the central features of the planning, organization, financing, regulation and evaluation of alternative organizational modes of health services delivery, with inputs from systems theory, health planning, health law, social security law, labour law, bioethics, industrial psychology, organization theory, interorganization theory, evaluation theory and political science;
- *quantitative analysis and management control*, providing the analytical and evaluative tools required for managerial performance with inputs from fields such as epidemiology, biostatistics, management techniques, accounting, microeconomics, industrial engineering, operations research, psychology and sociology, computer science;
- *communications*, providing skills in effective interpersonal, intra-organizational and external communication and based on such disciplines as psychology, sociology, anthropology and health education;
- *health economics and policy analysis*, developing appropriate insights and skills for understanding and analysing the economic aspects of the health care system and the political processes affecting it and based on such disciplines as economics and political science.

The rest of the degree programme should consist of educational experiences designed to provide specialization towards a given managerial profile or to develop a broader perspective concerning health care management. This modular approach should be flexible enough to accommodate mid-career training whereby experience and proven competence could be traded against credits of the core curriculum.

(b) Provision could be made to permit individuals employed in health administration to obtain the above-described academic degree by earning the required credits over a longer period and by other means than being a student in residence, e.g., correspondence courses.

6.2 A continuing education programme

This should provide practising managers at all levels in the health system with ongoing opportunities to improve their knowledge, skills and attitudes with respect to effective managerial performance in off-duty education formats compatible with their overall responsibilities.

Two major variants, not mutually exclusive, are possible:

- updating programmes aimed at raising to predetermined levels the knowledge and skills of a given group of managers with respect to a wide range of problems;
- issue-oriented programmes dealing with given problems, skills and tools for different categories of managers.

6.3 A health services research programme

This would provide a capacity to study, through multidisciplinary research and development, those factors and conditions which determine and affect the effectiveness and efficiency of health care delivery (*22*). Health services research should contribute to the building up, in an international context, of the theoretical basis on which both the academic degree and the continuing education programmes should rest. It should also, under conditions of applied research and development and within the national context, test hypotheses and findings of research in other countries, thereby providing empirical evidence, case studies and demonstration material to enrich the educational resources.

6.4 An organization development programme

Health organizations should agree upon collaborative arrangements, involving formally identified managers on their staffs, to improve their respective organizations. This would permit opportunities of structured development activities to be created in which the managers involved would learn and put into practice the knowledge and skills they have acquired in the degree programme and/or the continuing education programme, while at the same time contributing to real-life management improvement.

Interrelationships between the four programmes described above can result in mutual reinforcement. One may visualize the academic degree programme as the provider and/or facilitator of the continuing education programme. The provider role represents a higher degree of commitment, whereby the organizing and provision of continuing education is carried out with the resources of the academic degree programme and with the approval of its parent institution(s). Under the facilitator role the academic degree programme offers resources, participates in programme formulation and motivates continuing education (*23*). Such a provider or facilitator relationship between the two programmes not only permits the teaching resources base to be broadened but also leads to mutual adjustments in curriculum emphasis and content. It also provides an enriching confrontation between theoreticians and empiricists. The supportive role of health services research as a provider of knowledge and educational content has already been stressed.

Both the degree programme and the continuing education programme create a resource pool which allows students and practitioners to be involved in research design, data collection and data analysis, thereby not only teaching a rational and systematic problem-solving approach, but also permitting pilot studies under real-life conditions and demonstration and implementation projects. The social impact and credibility of health services research can thus be improved. Ultimately, health services research and continuing education can be geared towards strengthening the organization development programme, which in itself can identify issues and problems for health

services research, while at the same time it can, by supporting research, provide interesting care studies as inputs to degree education and continuing education.

The mutually reinforcing interrelationships described so far are exemplary and not all-inclusive. They demand a minimum of formal arrangements and structure, and they also require a lead-programme or a joint body which orchestrates the interactions.

6.5 Teaching staff development: a prerequisite

The most critical resource in management education and training is teaching staff. The current staffing pattern of most of the European programmes is not in line with the wide range of needed disciplines and expertise which was identified for the academic degree programme and should also be available to support the health services research programme, the continuing education programme and the organization development programme.

A serious developmental commitment is required to increase and to diversify health management education faculty and the health services researchers pool. Fellowships for doctoral studies and for health services researchers should become a priority so as to create the required critical body of qualified educators and researchers to man the programmes basic to health management.

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Annex II

AGENDA

1. Identification of basic management functions and classification of health service managers

2. Medical, social and administrative factors affecting the management of health services

3. Current management education programmes in health services in the European Region of WHO

4. Development of management education programmes in health services

5. Relationship between management education programmes and health services research

6. Promotion of national management education programmes and role of international collaboration

7. Conclusions and recommendations

Annex III

LIST OF PARTICIPANTS

Temporary Advisers

Dr Christa Altenstetter, Research Fellow and Associate Professor, International Institute of Management, Berlin (West)

Dr A.C. Eberwein, President, Academy for Public Health, Düsseldorf, Federal Republic of Germany *(Chairman)*

Dr E. Fjärtoft, County Public Health Officer, Steinkjer, Norway

Professor E. Johnson, Methods Research Group, Commercial High School, Copenhagen, Denmark

Dr E. Kröger, Director, Academy for Public Health, Düsseldorf, Federal Republic of Germany

Dr Vassiliki Lanara, Associate Director of Nursing Services, Evangelismos Medical Center, Athens, Greece

Dr A.S. Mason, Senior Medical Officer, Division IR (1), Department of Health and Social Security, London, United Kingdom

Mr C. O'Nuallain, Director, Institute of Public Administration, Dublin, Ireland

Ms P. Pisiren, Vice Director, Gehver Nesibe Health Educational Institute, Ankara, Turkey

Dr H. Poulsen, Director, Danish Hospital Institute, Copenhagen, Denmark

Dr G. Sassen,[a] Academy for Public Health, Düsseldorf, Federal Republic of Germany

Dr B. Skupnjak, Yugoslav Commission for Cooperation with International Health Organizations, Novi Beograd, Yugoslavia

Dr J. Vysohlid, Head, Department of Postgraduate Education in Medicine and Pharmacy, Prague, Czechoslovakia *(Vice-Chairman)*

Dr S. Wilfling,[a] Lecturer, Economics University, Office of Health and Social Affairs, Vienna, Austria

[a] Participation expenses not paid by WHO

Consultant

Professor J.E. Blanpain, Director, Department of Hospital Administration and Medical Care Organization, Leuven University, Louvain, Belgium *(Rapporteur)*

World Health Organization

Regional Office for Europe

Dr J.E. Asvall, Regional Officer for Health Planning and Evaluation *(Secretary)*

Dr W. Fritsche, Health Manpower Development Consultant

Dr R.M. Wiedersheim, Chief, Health Manpower Development

Headquarters

Dr A. Mejia, Health Manpower Systems

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* A limited number of copies of these reports are available to interested persons, on request, from the Regional Office for Europe, World Health Organization, Scherfigsvej 8, 2100 Copenhagen Ø, Denmark.